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ABSTRACT

A diagnostic-prescriptive teaching module on basic interviewing skills for first-year medical students is presented. The goal of the module is to help students refine interpersonal communications skills relative to the medical interview. The module provides information on the following skills: eliciting patient responses, interviewing techniques and terminology, observing and interpreting patient's methods of expression, and awareness and management of feelings evoked during an interview. Specific objectives include the following: (1) identify examples of interviewing techniques that are facilitative; (2) identify examples of open-ended questions, clarifying statements, recapitulation, focused questions, and empathic statements; (3) consider both the specific content of the interview and modes of expression when listening to patients; (4) identify kinds of linguistic communication and paralinguistic communication; (5) list four types of behavioral communication and five typical feelings expressed by patients; and (6) support the rights of patients to their own feelings, philosophies, moral codes, and life styles. Test items are included. (SW)

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DIAGNOSTIC PRESCRIPTIVE TEACHING MODULE: BASIC INTERVIEWING SKILLS

BY

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DIAGNOSTIC PRESCRIPTIVE TEACHING (DPT)

Intended Learners: Year I Medical Students

Goal: To practice and refine interpersonal communication skills relative to the medical interview.

Specific Objectives:

1. Given various interviewing techniques, the medical student will be able to identify with 90 percent accuracy examples of those techniques which are facilitative, those one should use with discretion, and those one should avoid. (Diagnostic Test Items 1 and 2)

2. Within the context of a medical interview, the student will identify two examples for each of the following techniques:

    a. Open-ended questions
    b. Clarifying statements
    c. Recapitulation
    d. Focused questions
    e. Empathic statements

    (Diagnostic Test Item 3)

3. When listening to patients within the context of a medical interview, the medical student will consider not only the specific content of the interview, but also the modes of expression. (Diagnostic Test Item 4)

4. Relative to the medical interview, the student will define, with accuracy, linguistic communication and paralinguistic communication. (Diagnostic Test Item 5)

5. From a selected list, the student will identify kinds of linguistic and paralinguistic modes of communication. (Diagnostic Test Item 6)

6. Relative to the medical interview, the student will list, without error, four types of behavioral communication. (Diagnostic Test Item 7)

7. Within the context of a medical interview, the student will list on paper five typical feelings expressed by patients. Diagnostic Test Item 8)

8. Given the medical interview, the medical student will support the rights of his(her) patients to their own feelings, philosophies, moral codes, and life styles. He(she) will also be mindful of his own feelings in the process. (Diagnostic Test Item 9)

Diagnostic Test Items:

1. There are interviewing techniques that are facilitative, those that are effective if used with discretion, and those which should be avoided. Identify the following interviewing techniques by writing facilitative, use with discretion, or avoid next to the technique.

(a)	clarifying statement:	facilitative
(b)	suggestive question:	avoid
(c)	closed question:	use with discretion
(d)	restatement:	facilitative
(e)	focused question:	facilitative
(f)	silence:	use with discretion
(g)	accusative question:	avoid
(h)	empathic statement	facilitative
(i)	denial:	avoid
(j)	multiple choice question:	use with discretion
(k)	compound question:	avoid
(l)	open-ended question:	facilitative

2. Match the item on the left with the item on the right by writing its number in the correct space.

1. open-ended question	1 "So, Mr. George," what's troubling you today?"
2. focused question	3 "Was the pain sharp, dull, or throbbing?"
3. multiple question	4 "Uh, huh."
4. encouraging cue	10 "It couldn't have been that bad!"
5. restatement	9 "Have you ever had syphllis?"
6. accusative question	6 "Why didn't you take those pills I gave you?"
7. suggestive question	7 "When you had the chest pain, did it radiate to your left arm?"
8. clarifying statement	5 "Let me summarize our contract..."
9. closed question	2 "Tell me about the breathlessness you mentioned earlier."
10. denial	8 "Tell me what led you to think you have cancer."

3. Match the item on the left with the item on the right by writing its number in the correct space.

1. Open-ended question
2. Clarifying statement
3. Recapitulation
4. Focused question
5. Empathic statement

_3_ "So, to summarize, then, you said the pain began when...."

_2_ "What led you to think you had angina?"

_5_ "I can see how that must have frightened you."

_1_ "What was it like?"

_4_ "How did the pain travel?"

_1_ "Can you tell me more about that?"

_5_ "That must have been very upsetting."

_4_ Pt.: "I suppose the worst of it is this stomach being upset all the time."

Dr.: "Tell me about what it's like when it starts."

_3_ Dr.: "Well, Mrs. Marshall, you've told me a lot about your back pain today. To summarize, you first noticed some tenderness in your back after you went back to work and it got worse as time went on. Is that right?"

Pt.: "Yes, 'til now; it's real sore."

Dr.: "And, you are bothered by it most at night."

Pt.: "Oh, so it's only after you've worked. Hum, you're not so bothered by it on weekends, when you don't work?"

_2_ "You've had some bronchitis before. Can you tell me more about that?"

4. Answer the following items by indicating "T" for True and "F" for False:

   T (a) Patients' communications often contain multiple levels of meaning.

   F (b) The content of a medical interview rather than the modes of expression often more accurately communicates meaningful data.

   T (c) Media for clinicians' observations of patients are language and behavior.

   T (d) Most eye contact behaviors are highly individual. It is change of pattern which gives the clearest message. For example, the speaker who maintains normal eye contact during most of a conversation, but looks away during a specific part of the discussion is usually expressing some strong affect.

5. People communicate with both linguistic communication and paralinguistic communication.

   (a) Define linguistic communication.

   Linguistic usage maybe defined as the actual spoken words, phrases, utterances, etc. as phenomena in themselves. Verbal communication.

   (b) Define paralinguistic communication.

   Paralinguistic usage may be defined as "how" something is said rather than "what" is said. Non-verbal communication.

6. Match the item or the left with the item on the right by writing its number in the correct space.

   1. Linguistic communication
   2. Paralinguistic communication

   2 Changes in speech rate
   2 Pauses
   1 Word choice
   1 Denotation and connotation
   2 Tone of speech
   1 Distancing or depersonalizing by pronoun shift

7. Behavioral communication refers to observed behavior, mannerisms, etc. which are not necessarily directly associated with, or part of, language. This aspect of expression is also less consciously controlled and, therefore, readily conveys valuative and affective data. List four types of behavioral communication:

   (a) body language
   (b) facial expressions
   (c) vocal, non-verbal behavior
   (d) eye contact

8. List five feelings evoked by patients in a medical interview by writing them in the spaces provided:

   (a) Anxiety
   (b) Helplessness
   (c) Depression
   (d) Anger
   (e) Satisfaction

9. Answer the following items by indicating "T" for True and "F" for False.

   T (a) An effective patient-physician relationship facilitates a productive interview.

   T (b) Patients can evoke a myriad of emotions in the clinician.

   T (c) Physicians are entitled to "positive" emotions as well as "negative" ones and often experience them in the course of patient care.

   T (d) If the interviewer suppresses feelings, the patient senses the lack of personal involvement and will react by limiting his or her personal disclosures.

   T (e) The physician needs to be sensitive to feelings of frustration and irritation to determine if they stem from the patient or from the physician.

   T (f) It is all right for the physician to say: "Yes, I do feel uncomfortable talking to this patient."

INTERPERSONAL COMMUNICATION SKILLS

Introduction:

Interpersonal communication skills are fundamental to human society. Medical practice requires special refinement of these skills and the medical interview is the cornerstone for their development. Medical students bring to their training a wide range of abilities in communicating with people but almost no "professional" experience interacting with people who have illnesses. This Diagnostic-Prescriptive Teaching Module is designed to supplement the medical students' clinical experience to achieve the most benefit from his or her interviews with patients. It contains the following categories:

A. Eliciting Patient Responses (Prescriptions: Objective 1 and 2)

B. Interviewing Techniques and Terminology (Prescriptions: Objectives 1 and 2)

C. Observing and Interpreting Patient's Methods of Expression (Prescriptions: Objective 3, 4, 5, 6)

D. Awareness and Management of Feelings Evoked during an Interview (Prescriptions: Objectives 7, 8)

A. Eliciting Patient Responses (Prescriptions: Objectives 1 and 2

1. Interviewer Behaviors:

The depth of an interview depends, in part, on how comfortable the patient is. There is no simple prescription for making the patient, or interviewer, comfortable with the interview, but making a conscious effort to be relaxed, honest, and professional will greatly contribute to the student's confidence and the patient's willingness to disclose personal and medical information. It is particularly important to have natural eye contact, responses that exhibit interest, and a respect for the patient as a person. With practice, the learned interviewing techniques will seem natural.

It is recommended that there should be no note taking during the interview. Especially during emotion-laden or very personal discussions, the patient should be given full attention. If notes are necessary during a particularly lengthy or complicated history, be as unobtrusive as possible. The best approach is to jot down key words in a vertical format and after the interview, fill in the details.

The medical interview is a process of learning about the patient, his or her presenting problem, and the psychosocial context of the presenting illness. Listening and questioning, observation, and integration are components of this process.

2. Listening and Questioning:

Obtaining relevent biomedical and psychosocial data require careful and attentive listening to and questioning about the patient's story. Responding to the patient with facilitative statements and open-ended questions signals that you are interested and thereby encourages the patient. If the patient is permitted to talk freely, he or she will often volunteer essential information that might not be elicited by direct questioning.

3. Observation:

Although observation is a main component of the physical examination, it is also an inseparable important part of the interview. Starting with the first contact with the patient, data obtained through observation contribute to the physician's knowledge and understanding of the patient: the patient's general demeanor, sense of physical and mental well-being, level of intelligence, socioeconomic status, alterness, and attitude toward his or her illness.

4. Integration:

Through careful listening, questioning, and observing, data can be integrated to formulate preliminary hypotheses during the interview. The hypotheses should be revised and checked for validity as additional information becomes available. These data provide the supporting evidence required for each hypothesis. Then, after the interview, inconsistencies, characteristic responses, evident stress, support systems, and other factors can be noted and used to formulate hypotheses pertaining to the psychosocial context of the presenting illness.

B. Interviewing Techniques and Terminology (Prescriptions: Objectives 1 and 2)

A medical interview will usually contain a variety of questioning and responding techniques, some more facilitative than others. The following list names, defines and gives examples of five of the most common interviewing techniques.

1. Facilitative:

Open-Ended Question - asks for information about an area without specifying the content. Used early in the interview, it helps the patient to tell a spontaneous story.

(a) "Can you tell me more about that?"
(b) "What was it like?"
(c) "Could you tell me more about when you first felt it?"

Focused Question - narrows the response by asking for specifics. Useful when trying to characterize a symptom or elicit descriptive data.

(a) "How did the pain travel?"
(b) Pt.: "I suppose the worst of it is this stomach being upset all the time."
Dr.: Tell me about what it's like when it starts."
(c) "Did the pain seem to radiate to your left arm?"

Encouraging Cue - verbally or nonverbally encourages the patient to discuss the problem. These cues are often subtle but very powerful in their impact.

Empathic/Reflective Statement - used when a patient is anxious or emotional, it can help to recognize the human feelings associated with the medical problem.

(a) "I can see how that must have frightened you."
(b) "That must have been very upsetting."
(c) "You must be under a great deal of stress right now."

Clarifying Statement - asks the patient to describe what he or she meant by the use of a medical term or other phrase that might have one meaning for the patient and another for the interviewer.

(a) "What led you to think you have angina?"
(b) "You've had some bronchitis before. Can you tell me more about that?"

Recapitulation or Restatement - summarizes or interprets the history and is of particular value when the story is complex or confusing.

(a) "So, to summarize, then, you said the pain began when..."
(b) "Let's get this from the beginning. Tell me about your fall."
(c) Dr.: "Well, Mrs. Marshall, you've told me a lot about your back pain today. To summarize, you first noticed some tenderness in your back after you went back to work and it got worse as time went on. Is that right?"
Pt.: "Yes, 'til now; it's real sore."

Dr.: "And, you are bothered by it most at night."
Pt.: "Right, after my shift."
Dr.: "Oh, so it's only after you've worked. Hum, you're not so bothered by it on weekends, when you don't work?"

2. Effective if used with Discretion

Multiple Choice Question - enables the patient to choose from a selection of descriptors. If the patient is having difficulty verbalizing symptoms, the physician can help by suggesting an array of adjectives to the patient.

(a) "Was the pain sharp, dull or throbbing?"
(b) "Do you have cramps, diarrhea, or vomiting?"

Suggested Question with Distractor - can be used when a specific bit of information is needed without overly influencing the patient's answer. The question contains one condition that is important and is "loaded" with another condition to distract the patient from providing the answer he or she thinks the physician wants to hear.

(a) "Did the pain radiate to your right arm or left arm, or did it stay concentrated in your chest?"

Closed Question - asks for specific points of information such as the presence or absence of a symptom, an exact date, or the name of a hospital. It often restricts the patient to a one word answer. It should be used only in combination with an open-ended question.

(a) "Have you ever had diabetes?"
(b) "When did the pain start?"

Silence - an important technique that permits the patient to tell an uninterrupted story. Used with FACILITATION, it encourages the patient to go into greater detail and to self-direct the content. If the patient begins to cry or lapses into silence because of overwhelming emotion, respectful silence is appropriate.

3. Should Be Avoided

Compound Question - covers a number of areas. Most patients become frustrated with the number and variety of answers expected of them, but they will often try to answer at least part of the question.

(a) "Did the pain make your breathing difficult. Did it travel anywhere? How long have you had the pain?"

Suggestive Question - suggests associated symptoms of an illness. They indicate to the patient that one symptom is more important than another in the diagnosis of a particular disease.

(a) "When you had the chest pain, did it radiate to your left arm?"

Accusative Question - tends to blame the patient. These place the patient on the defensive and should be avoided. "Why" questions should be used with discretion.

(a) "Why didn't you take your pills?"

Denial - occurs when either the physician or patient refuses to accept what was said by the other.

(a) "Oh, it couldn't have been that bad!"
(b) "But, doctor, my sister had the same operation last year and it didn't help her."

The chart which follows summarizes various interviewing techniques and terminology.

C. Observing and Interpreting Patient's Methods of Expression (Prescriptions: Objectives 3, 4, 5, 6)

Patients rarely, if ever, can be completely direct and comprehensive in providing data about their problems. The reasons for this are multiple and complex. However, one of the most significant of those reasons is that the media for clinician's observations of patients are language and behavior, both of which are richly symbolic or may be indirect in their meanings. Thus, it is the rule rather than the exception, that patients' communications will contain multiple levels of meaning. It is commonplace observation in everyday clinical encounters that patients' deepest concerns about their problems, especially feelings like fear, worry, or anger, tend to be denied, omitted, or circumlocuted. This is often referred to as the "hidden agenda," which is invariably expressed in a subtle or indirect manner.

Since it is clear that the clinician must first recognize the patient's problems and concerns about those problems before dealing with them, and since a patient's "concerns" about a problem may, in fact, equal or supersede the "problem" itself, there is a practical clinical need for developing facility in comprehensively interpreting patients' widely varied and multi-level modes of expression. Although superficially resembling ordinary conversation, the collection of data on these multiple levels requires a much

INTERVIEWING TECHNIQUES

TYPE OF INFORMATION	FACILITATIVE	USE WITH DISCRETION	AVOID
General The patient's spontaneous story of the illness or symptoms	OPEN-ENDED QUESTION "So, Mrs. Graham, tell me what is troubling you?" "What was it like?		COMPOUND QUESTION "What reason did you come to Emergency; was it because your leg was bothering you again or what concerned you most?"
Specific Narrow response; to characterize a symptom or elicit descriptive data	FOCUSED QUESTION "Tell me more about the breathlessness you mentioned earlier."	MULTIPLE CHOICE QUESTION "Was the pain sharp, dull, or throbbing?"	COMPOUND QUESTION "Did the pain make your breathing difficult; did it travel anywhere; and how long have you had the pain?"
Very Specific Restricts the answer to one word. Should be used only in combination with an open-ended question.	FOCUSED QUESTION "How did the pain travel?"	CLOSED QUESTION "Have you ever had diabetes?" "When did the pain start?" SUGGESTIVE QUESTION WITH DISTRACTOR "Did the pain radiate to your right arm, left arm, or did it stay concentrated in your chest?"	ACCUSATIVE QUESTION "Why didn't you take your pills?" SUGGESTIVE QUESTION "When you had the chest pain, did it radiate to your left arm?"
Encouragement Subtle but powerful cues to encourage discussion.	ENCOURAGING CUE "And then?" "Uh, huh." Nonverbal communication; leaning forward and nodding head, etc.	SILENCE Lets the patient tell an uninterruped story, disclose greater detail, and self-direct the content.	
Feelings Identification of the human feelings associated with the medical problem, especially if the patient is anxious or emotional.	EMPATHIC/REFLECTIVE STATEMENT "That must have been very upsetting." "I can see how that must have scared you."	SILENCE Respectful quiet and facilitation is appropriate if the patient needs to cry or lapses into overwhelming emotion.	ASSUMPTIVE STATEMENT "You must have been angry when they said you have leukemia." DENIAL "Oh, it couldn't have been that bad!" "I know just what you mean. My sister had that same operation last year."
Clarification To establish the patient's meaning of the use of a medical term or common phrase.	CLARIFYING STATEMENT "What led you to think you have angina?"		
Summarization To summarize or interpret the history especially if the story is complex or confusing.	RECAPITULATION or RESTATEMENT "So, to summarize, then, you said the pain began when. . .?		

higher degree of concentration and mental effort. The result is worth it; keener accuracy of understanding, greater therapeutic effectiveness, and deeper human richness.

Thus, it becomes important when listening to patients to consider not only the specific content, which usually will be found to be incomplete, but also to consider the modes of expression used therein which will further-and, often, more accurately-communicate meaningful data.

1. CONTENT OF EXPRESSIONS

In general, patient communications may be conceptualized as being comprised of cognitive, valuative, and affective content.

a. Cognitive data are factual and informational, such as dates, names, places, times, symptoms, understandings, and ideas. These are usually conveyed consciously, i.e. with specific intent, using primarily direct or denotative communication.

b. Values are judgments and attitudes of what is good or bad, desirable or undesirable, and are usually implied, i.e. conveyed by connotation.

c. Affective content includes emotions, moods, and affects, all of which are rarely directly expressed.

The fact that the latter two categories are not usually directly expressed does not make them any less valuable data sources, since, as stated above, these matters may exceed in meaningful importance the cognitive content.

2. MODES OF EXPRESSION

People communicate with both language (linguistics and paralinguistics) and behavior. The use of either may tend to be direct and multi-layered in meaning.

a. Linguistic usage may be defined as the actual spoken words, phrases, utterances, etc. as phenomena in themselves. Although chosen more or less consciously, words and their combinations may convey both direct meanings (denotation) and indirect meanings (connotation).

(1) Denotation. The vast majority of speech is in the service of straightforward exposition, ordinary conversation, and intentional, factual communications.

(2) Connotation is provided by a number of various linguistic mechanisms:

(a) Word choice (loaded and unloaded words): "My stiff knee has disabled me" probably means something quite different from 'My stiff knee has crippled me".

Use of euphemism is also a connotation mechanism, heard especially in communications regarding lethal illness and sexuality. For example, a patient uses "my private" instead of "my penis."

(b) Distancing or depersonalizing by pronoun shift: a linguistic mechanism whereby a speaker very subtly changes personal pronouns (I, me, my, mine) to impersonal pronouns (one, ones, you, yours, it, its) or even to articles (the, a, an) when discussing value-laden matters. Thus, "my leg" when unafflicted may become "the leg" when being described as afflicted.

For example:

(Patient asks physician) "If you see something on the mammogram, does that mean *you* have to have *the* breast removed?"

OR

(Patient giving a history of her leukemia) "It seems that *I* was healthly for 44 years and *my* blood was okay; but then when *you* get leukemia *one* is tired, like anemic....."

(c) Clues to missed meanings. When a listener misses the "real" or intended (but not explicit) meaning of a speaker's communication, it may be signalled by apparent illogic or repetitious allusion.

For example:

DR.: Tell me about your abdominal pain.

PT.: It's right here (pointing to epigastric area), and comes on and off. It started about one year ago, *after my husband retired*. It's not bad most of the time.

DR.: What seems to make it worse or better?

PT.: Well, I think food helps, except coffee makes it worse. *My husband thinks it's my nerves.*

[Signal: Patient may need to express the problems brought about by her husband's retirement.]

Usage of apparent illogical thoughts will be noticed when a patient continues to ask the same question or pursues the same route of discussion despite satisfactory answers to the question.

b. Paralinguistic usage may be defined as "how" something is said rather than "what". This mode of usage is chosen less consciously and thus is well suited to the communication of valuative and affective data.

(1) Pauses. Although many pauses are simply language formation time, they may also communicate feelings. For example; (Patient asking doctor about his illness): "Doctor, could this be (pause) *er*, (pause) *serious?*"

Note the use of both pause and euphemism which here reflect feelings of fear.

(2) Changes in speech rate. Decrease in rate of speech (especially over longer times) may be symptomatic of depression as well as endocrine disturbances. Increases in rate may indicate either anxiety or excitement.

(3) Tone of speech. (Pitch, volume, and degree of modulation of these.) Any change in these parameters of speech usually reflects underlying affect, asking to be recognized. The shifts may be subtle, but are highly reliable.

(4) Change of subject. May indicate either that the speaker wishes to approach more valuable material (usually the reasons for this shift are obvious), or that he or she wishes to avoid anxiety-provoking material (which is usually less obvious). It is axiomatic that what is not said is frequently more value or affect-laden than what is said.

Paralinguistic usages frequently do not convey readily identifiable specific feelings or values. They may simply function as clues that the patient attaches affect or value in that area. Recognizing these clues, an alert interviewer will seek to elicit more direct expression of the patient's subtly expressed feelings and ideas.

c. Behavioral communication. This category refers to observed behavior, mannerisms, etc., which are not necessarily directly associated with, or a part of, language. This aspect of expression is also less consciously controlled and, therefore, readily conveys valuative and affective data.

(1) Body language. Direction of body lean, directness of facing, muscular relaxation or tension, bouncing of a crossed leg, drumming of fingers, clenched hands or fingers, crossed fingers, crossed arms, nodding of the head, etc. may all convey meanings. Although in recent years there have been various popularized efforts to assign specific meanings to particular behaviors, it is important to realize that the meanings of these behaviors are highly individually variable. Therefore, any interpretations should be initially tested by correlating and/or seeking other observations.

(2) Facial expressions. Smiling, frowning, facial immobility, lip tension, etc., may all convey emotional data. Paradoxically, facial expressions are often used habitually to conceal feelings. It It is the variation in usage that can be observed and interpreted.

(3) Vocal, non-verbal behavior. Laughing, giggling, chuckling, weeping, etc. usually are fairly direct in their meanings. However, they too may indicate paradoxical or masked feelings, e.g., the "nervous giggle" of some adolescents or the anxious laugh of some adults. Such non-customary usages are highly specific to individuals, but once perceived by the careful listener are highly reliable and uniform for the same individual.

(4) Eye contact. Most eye contact behaviors are also highly individual, and thus it is change of pattern which gives the clearest message. For example, the speaker who maintains normal eye contact during most of a conversation, but looks away during a specific part of the discussion is usually expressing some strong affect.

Tearing (as opposed to overt weeping) may be very subtle, and likewise expresses strong affect, not necessarily negative.

3. CLINICAL APPLICATION

Some general principles for the use of the above concepts may be identified.

a. The less direct is any communication, the more individually variable it is. Thus, Paralanguage will be more individualized than Language. In contrast to words per se, whose denoted meanings can be agreed upon within reasonable cultural limits (e.g. the dictionary), connoted meanings, paralanguage, and behavioral communications will not convey meanings as uniformly from speaker-to-speaker. Thus it is necessary to test and confirm any hypothesis about a speaker's intent before drawing conclusions from the content.

b. Body movements, facial expressions, and gestures reveal much more about attitudes and emotional state than words.

c. When linguistic and paralinguistic data conflict, the latter are usually the more reliable.

d. Nonverbal behavior often does project the truth.

e. Research has found that people look either to the right or to the left, depending on what thoughts dominate their mental activity. Most people are generally classified as right lookers or left lookers. Left lookers are found to be more emotional, subjective, and suggestible; whereas, right lookers are more influenced by logic and precision.

f. All of the above principles of communication operate in both directions during a clinical encounter. That is, both covert and overt information are exchanged between physician and patient <u>in each direction</u>. There are, however, two differences with regard to the physician's usage:

   (1) <u>Degree of expertise</u>. The physician is, it is to be hoped, practiced and skilled in such usages so that he or she can be the more effective interpreter as well as communicator.

   (2) <u>Role</u>. The physician is cast in a helping role, and thus will be expected to use (among many different means) expressive skills that help the patient to "feel better" as well as to inform. For the many reasons outlined above, paralanguage and behavorial style (demeanor) will accomplish this much more effectively than ordinary conversation.

D. Awareness and Management of Feelings Evoked During an Interview (Prescriptions: Objectives 7, 8)

Reasonably self-aware clinicians learn to trust their feelings about patients. In addition to listening to the content and mode of delivery of the patient's story, a clinician can give attention to his or her own personal reactions to the patient. Used with other data sources, this is a valid, although indirect, way of learning about the patient. Identifying and managing these feelings is an important introspective process that helps to improve clinical effectiveness.

An effective patient-physician relationship facilitates a productive interview. Because decisions and hypotheses are based upon data, increased amounts and sources of data enable the clinician to make more accurate judgments. Therefore, to ignore the feelings evoked by the patient is costly in two ways. 1) A valuable data source is not utilized. With experience, the clinician learns to rely on his or her feelings and impressions of the patient and refers to other data sources for corroborating or disproving evidence for those feelings. 2) The rapport with the patient is reduced. When a patient is asked to relate biomedical and psychosocial information, he or she enters into a personal conversation with the interviewer and expects some personal reaction to what he or she is saying. If the interviewer suppresses feelings, the patient senses the lack of personal involvement and will react by limiting his or her personal disclosures.

Patients can evoke a myriad of emotions in the clinician. Identifying the specific emotion requires the clinician to realize that affective responses are part of clinical encounters and the clinician is no less professional to admit them. A useful question to ask oneself is "what is my reaction to this patient?" It is important to honestly label the feeling and to investigate its source.

As human beings, physician's emotions are affected by events of their own personal lives. For example, a fight with one's spouse can modify one's attitude to the patients seen shortly thereafter. In assessing your emotional reaction to a patient, it is important to keep in mind your "background" emotional state.

Examples of some typical feelings evoked by patients are discussed below:

1. IDENTIFICATION

a. Anxiety. Anxiety is a significant part of physicians' daily activities. Patients are often tense and worried and the physician may recognize this anxiety and empathize with it. In addition, patients provoke anxiety in physicians by presenting complex problems to a physician with a jammed schedule, by presenting with a threatening litigious approach, by subtly questioning the doctor's credentials, and other mechanisms. Physicians may feel anxiety brought on by the urgency, pace, and consequence of the tasks and decisions required of them. Responding to high pressure situations by feeling anxious is the reaction of a healthly person, but effective management sometimes requires special effort and is important to maintaining clinical competence and personal health.

b. Helplessness. Being able to help a patient is the main objective of health care professionals. But often situations arise where the clinician feels helpless. Sometimes the source of this feeling will be apparent: uncertain diagnosis, gaps in medical science, or insufficient facilities to deal with the problem. The source of feeling helpless can also be vague, where the nature of the patient's personality makes the clinician feel helpless. Feeling helpless when responsible for a person's care can be a discomforting experience that warrants introspection. Questions to ask oneself are: "Are my feelings due to a lack of my skills?" "To a gap in medical science?" Or, "Are my feelings the result of something that is being communicated to me by the attitude or personality of the patient?" A patient, out of his or her own reaction to being ill and under the care of other people, may try to make others feel helpless. In this case, the interviewer should hear this call for help and explore these feelings with the patient.

c. Depression. Physicians see many depressed people in daily practice. With patients whom they have cared for over a long period, physicians may easily share the sadness of present or impending personal loss. Sometimes a string of losses can lead to a sense of depression in the physician not related to individual patients.

d. Anger. Anger is another normal but often "socially unacceptable" emotion. A patient who, for example, repeatedly refuses to comply with his or her regimen can provoke frustration and anger in the physician. There are also less obvious cases in which the clinician feels hostility toward the patient but without easily

ascertainable cause. The "passive-aggressive" personality for example, psychologically thrives on making people in authority angry at him. The physician needs to be sensitive to feelings of frustration and irritation to determine if they stem from the patient or the physician. A patient may inadvertently remind the physician of someone from his or her personal past who aroused strong negative emotions.

e. Satisfaction. Physicians are entitled to "positive" emotions as well as "negative" ones and often experience them in the course of patient care. Patients express thanks for efforts on their behalf. Even with this emotion, it is valuable to be introspective, sometimes wondering if a patient is perhaps overly praising because of a hidden agenda, e.g., the seductive patient.

2. MANAGEMENT

A clinician has personal and professional responsibilities for managing the feelings evoked during an interview. The physician should accept responsibility for the feeling by admitting, for example, "Yes, I do feel uncomfortable talking to this patient." Labeling the feeling is an important step in management. Realize that it's all right to have this feeling, but that it should not impair the quality of the patient's care. If the feeling can't be dealt with when it arises, as is often the case, the physician should promise himself or herself to deal with it later. Set aside an uninterrupted time when the feeling can be explored in all its breadth, depth, and intensity. Often sharing it with a colleague or loved one can be valuable. Eventually, the clinician will become more adept at recognizing and dealing with feelings and will use them to provide effective patient care.

Criterion Test Items:

The nine questions from the Diagnostic Test now become the Criterion Test Items. For variety, questions 2 and 3 could be rewritten into the four vignettes which follow. Questions 1 and 4-9 could be changed to simple True/False statements, multiple recognition questions, completion questions, matching questions, or another format.

Directions for Questions 2 and 3 - VIGNETTES:

1. Study "Interviewing Techniques and Terminology (Prescriptions: Objectives 1 and 2). For each vignette which follows, indicate in the space provided next to each statement, the

appropriate label for the response. (There may be more than one acceptable answer.)

2. Then, for each vignette, indicate your choice of the most appropriate response by circling the letter next to your choice.

3. Write a concise statement of your reason(s) for choosing that response.

VIGNETTES

#1. A 51-year-old white male presents with chest pains and shortness of breath, but is feeling no symptoms at the time of the interview.

Pt.: "It hit me so fast. I was in the hardware store, when just like that, I get this shooting pain in my chest. Knocked the wind right out of me."

Response type:	Response:
A._____	"Did the pain seem to radiate to your left arm?"
B._____	"I'm sure that must have scared you."
C._____	"Could you tell me more about when you first felt it?"
D._____	"Describe that problem you had with your breathing?"

Reason for choosing response:

_____

_____

_____

#2. A 20-year-old black male, formerly a high school track and field athlete, presents with a slightly swollen, tender knee.

Pt.: "I'm trying to get into running again, but my knee, since I fell on it last winter, has seemed sort of stiff; I can't bend it too good."

Dr.: "Uh, huh."

Pt.: "Like, yesterday, I ran about a mile or so. That's all I could do. I walked the rest of the way home."

Response type:	Response:
A._____	"Let's get this from the beginning. Tell me about your fall."
B._____	"You said you had a fall. What kind of fall, uh, what happened to your knee?"
C._____	"So, it's painful only when you try to run or strain it?"
D._____	"And, then what happened?"

Reason for choosing response:

_____

_____

_____

#3. A 40-year-old white female, recently divorced with custody of her three children between the ages of 12 and 19, presents for the first time with chronic headaches.

Pt.: "What should I do? I can't go on with these headaches!"

Response type:	Response:
A._____	"I would recommend a series of tests to determine the cause of your headaches. What do you think?"
B._____	"You must be under a great deal of stress right now."
C._____	"There are a variety of options open to you. We'll need to discuss what's best for you."

D._____ "Tell me more about what they're like, and when they seem to come on."

Reason for choosing response:

_____

_____

_____

#4. A 15-year-old female, high school student, presents with a cold, and has come to your office at the insistence of her mother. She has a history of bronchitis.

Pt.: "There's nothing wrong with me. My mother thinks that every time I get a cold I'm going to die or something. Everybody coughs when they get a cold."

Response type:	Response:
A.	"And you feel she is being over-protective of you?"
B.	"You've had some bronchitis before. Can you tell me more about that?"
C.	"Can you tell more about your cold and the cough?"
D.	"What's the cold like?"

Reason for choosing response:

_____

_____

_____

Management Details:

The following checksheet is used to keep record of each student's progress. (Check (✓) when completed.)

Name of Student_____ Lab Number_____

Phone Number_____

Objective: 1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

Diagnostic Test Item	Date Completed	Comments
1._____		
2._____		
3._____		
4._____		
5._____		
6._____		
7._____		
8._____		
9._____		

Criterion Test Item	Date Completed	Comments
1._____		
2._____		
3._____		
4._____		
5._____		
6._____		
7._____		
8._____		
9._____		

A conferencing schedule is set up weekly to meet with each student.

Goals: Review work. Use checksheet in discussion with student.

Appraise Knowledge and Retention

Evaluate Progress

General Observations

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